Client Name Andrew Root Medicaid # N/A

Birthdate 6-22-77 Insurance # OLG 07162101

Permission for treatment/services

Freedom of Choice

I understand that the choice of providers is my responsibility and right as the client or guardian. I further understand that I have the right to contact the providers prior to selection so that I may determine the best provider. I also understand that I may at any time choose another provider for this service by notifying my current provider.

Informed Consent

I understand that participation in treatment does not guarantee anticipated outcomes. I understand that there may be unintended results of treatment affecting the client and other family/household members. I understand that providers are legally bound to report suspected abuse of the client or of other family members. I also understand that the providers have a duty to warn any intended victim of a threat to harm.

Persons Participating in Home and Community Based Services

I understand that I am giving permission to include in the client's treatment sessions any persons present in the home, school or community at the time of service. This includes but is not limited to myself, parents, spouses, step-parents, paramours, siblings, children, extended family, household visitors, caregivers, playmates and classmates. I also understand that I have the right to dismiss anyone from participating in a session at any time and that I have the right to exclude anyone from the ongoing treatment process by written notice to the provider.

Telehealth Services

I understand that telehealth services maybe recommended as part of treatment. I have received information on the limits and process of telehealth and consent to telehealth care services.

Privacy Practices

I understand that Transformations adheres to the Health Information Privacy Act and I agree to these practices. I agree that this information has been made available to me for me review.

Responsibilities

I understand my responsibility is to: 1) provide accurate information and report any changes in client wellbeing, 2) to keep all appointments and to give 24 hour notice of a need to reschedule, 3) to maintain the client's insurance coverage and report any lapse in coverage to the service provider, 4) to contribute to a plan of treatment and to follow through with agreed upon interventions.

I understand that I am financially responsible for any services received. I agree to report all primary and secondary insurance coverages. I agree to pay any co-pay, deductibles, and co-insurance agreed upon with my insurance company. I give permission to file insurance claims on services provided with any insurance companies with which I or my child is enrolled. I give Transformations permission to file treatment plans to request authorization for services. I also understand that a treatment plan may include information such as diagnosis, symptoms, treatment goals, and progress reports. This release includes any dependents for which Transformations staff is also providing treatment

Permission is hereby given to Transformations staff and its service providers to render screening, assessment, treatment and support services to the above-named client and under the above-named conditions.

Signature of Client

Signature of Parent or Legal Guardian Relationship to Client

Witness Date 10-18-19

Client Name Andrew Root Medicaid # N/A

Birthdate 6-22-77 Insurance # DLG 07162101

Client and Payment Information

Client Address 132 Cordelia Dr City/State/Zip Mount Washington KY 40047

Client SS#: 409-49-6209 Guardian name /address

Phone # 812-461-8828 Email aroot23@gmail.com

Foster parent/ address/phone

I understand that I am financially responsible for any services received. I agree to pay Transformations any co-pay, deductibles, and co-insurance agreed upon with my insurance company. *I give Transformations permission to file insurance claims on services provided with any insurance companies with which I or my child is enrolled. I give Transformations permission to file treatment plans to request authorization for services. I also understand that a treatment plan may include information such as diagnosis, symptoms, treatment goals, and progress reports. This release includes any dependents for which Transformations staff is also providing treatment.*

PRIMARY INSURANCE: **Provider must obtain a copy of both sides of all insurance cards**

__ Medicaid X Private Insurance (primary over Medicaid) __ Medicare (primary)

Policyholder (if other than client) Policyholder's Date of Birth

Policyholder address (if different from client)

Primary Insurance Company Name Blue Cross Blue Shield

Policyholder's Employer (if applicable) Dollar General

Policy Number DLG07162101 Group # 87898

Social Security # of Policyholder (if other than client) Payor ID

SECONDARY INSURANCE:

___ Medicaid (secondary to other insurances) ___ Private Insurance (secondary to Medicare)

Policyholder Policyholder's Date of Birth

Policyholder address (if diffcrent from client)

Secondary Insurance Company Name

Policyholder's Employer

Policy Number Group #

Social Security # of Policyholder (if other than client) Payor ID

CLIENT PAYMENT RESPONSIBILITIES

Private pay agreement

Transformations accepts credit cards, checks, money orders and cash payments. Payment is expected at the time of service and arranged with your service provider.

Client or Guardian Signature Date 10-18-19

Witness LMFT **Date** 10-18-19

Client Name Andrew Root Medicaid # N/A

Birthdate 6-22-77 Insurance # OLG-07162101

Screening and Mental Status Exam for Adults

Symptoms Check List: Please indicate what symptoms you are experiencing and the severity by making it with a number between 1 and 10 with 10 being the most severe.

Activity:
___Decrease in energy or fatigue
___Hyperactivity
___Impulsive
___Restless
___Physically slowed
✓Physically agitated
___Excessive social, work, or playful activities

Behaviors:
___Work difficulties
___Aggressive
___Violent
___Compulsions
___Dishonesty or theft
___Destructive
✓Disorganized
___Oppositional or defiant
___Reckless
___Self-injurious
___Violation of the rules or rights of others
___Legal problems

Anxiety
✓Anxiousness
✓Fear of separation
___Jitteriness
✓Panic attacks
___Phobias
___Worry about _____

Mood
___Mood swings
✓Angry
___Tearfulness
___Depressed mood
___Excessive guilty
___Elevated mood
✓Feeling worthless
___Helpless
___Hopeless
___Irritability
___Hostility
___Loss of interests
___Loss of pleasure or apathy
___Low self-esteem

Sleep Disturbance
___Early morning waking
___Hypersomnia
✓Insomnia

Memory/ Attention
___Easily Distracted
✓Difficulty Concentrating
___Indecisive
___Poor judgment
___Memory loss

Thought and Speech
___More talkative than usual
___Urge to keep talking
___Racing thoughts
___Confused thinking
___Slurred speech

Perceptions and Thought Content
___Delusions
___Hallucinations (visual, sounds, touch, smells, etc.)
___Bizarre or unusual thoughts
___Obsessive thoughts
___Paranoid thoughts
___Not feeling real/ depersonalization
___Grandiose thoughts
___Thoughts of suicide or death
___Thoughts of a distressing event or flashbacks

Eating Disturbances
___Binge eating
✓Loss of appetite
___Increase in appetite
___Inability to maintain a stable body weight
___self-induced vomiting

Substance Use
Type _____
___Work or family conflict over use
___Inability to decrease use
___Persistent desire for substance
___An increase in tolerance
___Withdrawal symptoms
___Excessive time to obtain, use, or recover
___Legal problems _____

Provider name, credentials, and date Teresa Hoyt CMFT 10-18-19

Client Name Andrew Rost Medicaid # N/A

Birthdate 6-22-77 Insurance # OLG 071621O1

PHQ-9 Patient Questionnaire

In an effort to provide the highest standard of care and meet the requirements of your insurance company, we ask that you fill out the form below. This form is used as both a screening tool and a diagnostic tool for depression. Your provider will discuss the form with you during your visit. Thank you for your cooperation and the opportunity to care for you.

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?

	Not at all=0	Several days=1	More than half the days = 2	Nearly every day=3
1. Little interest or pleasure in doing things			3	
2. Feeling down, depressed, or hopeless.			3	
3. Trouble falling/staying asleep, sleeping too much.			3	
4. Feeling tired or having little energy.			0	
5. Poor appetite or overeating.			3	
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.			3	
7. Trouble concentrating on things, such as reading the newspaper or watching television.			3	
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.			1	
9. Thoughts that you would be better off dead or of hurting yourself in some way.		0		
Add columns		+	+	= 19 Total score

10. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all | (Somewhat difficult) | Very difficult | Extremely difficult

Total Score and Depression Severity: 1-4 minimal 5-9 mild 10-14 moderate (5-19 moderately severe) 20-27 severe

Client Name Andrew Root Medicaid # N/A

Birthdate 6-22-77 Insurance # DLG 07162101

Authorization to Share Information with Primary Care Physician

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services, KRS 304.17A-555, and under the federal regulations governing of Alcohol and Drug Abuse patient Records 42 CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This Authorization to Share Information will automatically expire one year after the date of your signature.

Electronic Records are preferred. Send by Fax to 502-899-5411 or Secure Email at office@transformationsllc.net

Select one:

✓ **I give permission to my Physician and to Transformations to share any applicable information from my Protected Health Information including immunization, treatments, behavioral health treatment plans, recommendations and other health care records.**

___ **I do not give my Physician and Transformations permission to share my protected health care information.**

Primary Care Physician Name, Address, Email Address & Fax Number

Dr. Akshaya Patel
~~Contact One Health~~ Baptist Health
8FFF 10216 Taylorsville Rd Louisville KY 40299

Patient or Guardian signature please 10-18-19 *date*

Date of consult 10-18-2019

Diagnosis with Code _____
and a brief description of presenting problem
A moderately severe depression PHQ-9 score of 19 related to a marital divorce.

Recommendations:
✗ Medication evaluation and monitoring for benefits, side effects and safety. _____
___ Medical monitoring for health concerns: _____
Other: _____

Signature of Provider/credentials [signature] LMFT Date Faxed or Mailed _____